Work Related Accident

About You

Today's Date: _____/_____/_____
Name_____
Address_____
_____
Home Telephone _____
Cell Number _____
Work Number_____
Birthdate_____
Social Security #_____
Spouse Name_____

Work Related Accident

Date of Accident _____/_____/_____
Time of Accident _____

Name and Address of Employer
_____
_____
_____
_____
Employers Telephone _____
Name of your supervisor:
_____
Have you reported your accident to your employer?
Yes No
Do you have a claim number, if so, please write it down._____

Have you gone to a hospital? Y N
Which one?_____
How did you get there?
Ambulance or private transportation

Describe any treatment you received while at the hospital:
_____
_____
_____
_____

Please write the name of your medical doctor below. If you have seen them for the injury, describe any treatment that you have received.
_____
_____
_____
_____

Please describe how you felt immediately after the accident?
_____
_____
_____
_____

Have you missed any days work? If yes, list the dates.
_____
_____
_____
_____

Have you had a work injury before? Y N

If yes, what year was the injury?_____

Describe the events that occurred just before and during your accident:
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Describe the Injury

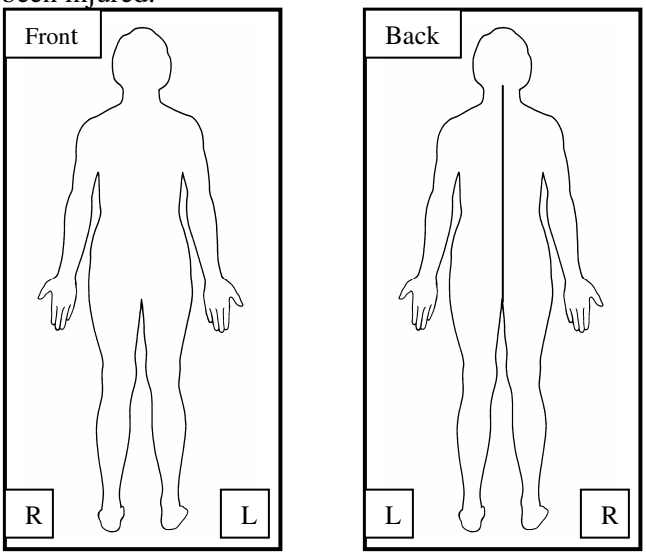
Place an X next to the symptoms that are a result of this accident:

	Neck Pain		**Numbness in legs**
	Mid-back Pain		**Numbness in Arms**
	Low-back Pain		**Numbness in Hands**
	Headaches		**Difficulty Sleeping**
	Shoulder Pain		**Pins & Needles in Arms**
	Leg Pain		**Pins & Needles in Legs**
	Foot/Ankle Pain		**Chest Pain**
	Nervousness		**Dizziness**
	Fatigue		**Nausea**
	Loss of Balance		**General Tension**
	Jaw Pain		**Depression**
	Buzzing in Ears		**Stomach Upset**
	Loss of Memory		**Shortness of Breath**

Indicate your degree of comfort while performing the following activities by placing an X in the box:

	No Pain	**Uncomfortable**	**Painful**
Lying on back			
Lying on side			
Lying on stomach			
Sitting			
Standing			
Stretching			
Walking			
Running			
Bending			
Kneeling			
Pulling			
Pushing			
Reaching			

Shade or Mark with your pen the areas that hurt or have been injured.



Recovery

Please place an X in the box next to your daily job duties and any activities that you are occasionally asked to perform:

Hours per day	**1-4**	**4-6**	**6-8**
Standing			
Sitting			
Kneeling/Squatting			
Twisting			
Bending/Stooping			
Pushing/Pulling			
Overhead reaching			
Other reaching			
Grasping/Squeezing			
Typing			
Climbing stairs/ladders			
Walking			
Running			
Operating equipment			
Crawling			
Lifting			
Answering the telephone			

Briefly describe your job responsibilities.

_____

_____

_____

_____

While in recovery, is there any light duty work that could be requested?

_____

_____

How many hours are in your normal workday?

_____

I hereby swear that all the information given is factual.

_____

Print Patient Name/Guardian

_____

Signature Patient Name/Guardian **Date**